

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154014	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/30/2015
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NAME OF PROVIDER OR SUPPLIER OTIS R BOWEN CENTER FOR HUMAN SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1535 PROVIDENT DR WARSAW, IN 46580
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A 0000 Bldg. 00	<p>This visit was for the investigation of one Federal hospital complaint.</p> <p>Complaint Number: IN00183375 Unsubstantiated; lack of sufficient evidence. Deficiency cited unrelated to the allegations.</p> <p>Date of Survey: 12/29/15 and 12/30/15</p> <p>Facility Number: 005179</p> <p>QA: cjl 01/04/16</p>	A 0000		
A 0123 Bldg. 00	<p>482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. Based on document review and interview, the facility failed to provide the patient/client with a written notice of</p>	A 0123	<p>A 123 The organization has corrected the deficiency by</p>	01/18/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>its decision following the filing of a grievance with the facility (Client #4).</p> <p>Findings Include:</p> <p>A. Review of the policy Client Records/Client Rights, Customer Grievances and Resolution of Client Dissatisfaction with Services, procedure number V - 512 (R 06), last approved on 3/9/10, indicated on page 3 under section 4.9.1 that The Performance Improvement Specialist or designee shall follow-up with the customer by telephone, letter or interview concerning the resolution of the grievance and follow-up on improvements made.</p> <p>B. Review of the log of complaints between 7/1/15 and 12/29/15 indicated Client #4 had filed four complaints during that time frame.</p> <p>C. At 10:10 AM on 12/30/15, interview with staff member #51, the Vice President of services, confirmed that:</p> <ol style="list-style-type: none"> 1. Complaints and grievances are considered the same for this facility, there is no differentiation between the two. 2. No written notices were provided to client #4 in response to their four complaints filed with the facility. 3. The facility currently does not provide written responses to customer complaints. 		<p>modifying the policy and procedure to require that a letterbe sent at the conclusion of an investigation and resolution of all grievances.Furthermore, at the recommendation of the surveyor, the organization hasdistinguished between a simple complaint, easily addressed without formalinvestigation and resolution and a grievance which does require formalinvestigation and resolution. You will find the policy and a draft copy of theletter that will be used as a cover page for the description of theinvestigation and resolution that the client will receive.</p> <p>·The letterwas created on January 14, 2016 by the Senior VP of Performance and Compliance</p> <p>·Policy V-512“Customer Grievances and Resolution of ClientDissatisfaction” was modified on Sunday, January 17, 2016 by the Senior VP ofPerformance and Compliance and formally approved on Monday, January 18, 2016,by the Chief Executive Officer.</p> <p>The deficiency will be prevented by including the “letterbeing sent” with the summary of the investigation and resolution as part of themetrics the organization uses to monitor the complaint/grievanceprocedure. The Senior VP of Performanceand Compliance will</p>				

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A 0438 Bldg. 00	<p>482.24(b) FORM AND RETENTION OF RECORDS The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.</p> <p>Based on document review and interview, the facility failed to ensure that group and individual therapy notes were completed within 72 hours of the day of service, as per policy, for 7 of 10 clients (Clients #1, #2, #4, #7, #8, #9 and #10).</p> <p>Findings Include: A. Review of the policy Fiscal/Data Management, Superbills, Supernotes, procedure number II - 509 (R 06), last approved 10/8/09, indicated under Procedures: 4.3 that The Clinician shall complete his/her notes in accordance with the instructions provided with each form...and in .1.1, that: Outpatient therapists who work in an office, seventy-two (72) hours from date of service.</p>	A 0438	<p>monitor the metrics and ensure that a letter is sent with a description of the investigation and resolution.</p> <p>A 438 The organization has corrected the deficiency by creating a policy that clearly defines the length of time a clinician has from the completion of a service to the submission of the clinical documentation for that service. The Policy is V-539 "Clinical Documentation Timeliness". The organization already has a procedure to monitor clinical documentation timeliness and as a result, the clinician indicated in the deficiency statement has recently been placed under a plan for improvement. Part of that plan includes her Administrative and Clinical Supervisors monitoring the completion of documentation in a timely fashion. Failure to comply with the documentation timeliness guidelines going forward will result</p>	01/20/2016

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	<p>B. Review of client medical records indicated:</p> <ol style="list-style-type: none"> 1. Clients #1 and #2 attended a group session on 12/10/15 with the notes not submitted until 12/17/15, which was beyond the 72 hours required by policy. 2. Clients #4 and #8 attended a group session on 9/3/15 with group notes not submitted until 10/6/15 and no individual notes done, as required. 3. Client #7 attended a group session on 9/24/15 and had a group note submitted late on 10/6/15, and lacked an individual note for that date. 4. Clients #9 and #10 attended a group therapy session on 12/17/15 and had no group or individual notes submitted as of 12/30/15. <p>C. At 9:00 AM on 12/30/15, interview with staff member #51, the vice president of services, confirmed that:</p> <ol style="list-style-type: none"> 1. Superbills and Supernotes are the same as group notes, now written on line, but previously on particular forms. The policy needs to be updated to reflect the changes. 2. There were no group or individual session notes for the 12/17/15 therapy session. 3. Staff member P2 has been deficient in following the policy related to time frames for documenting and submitting group and individual therapy session 		<p>in disciplinary action up to and possibly including termination.</p> <p>The policy V-579 was written on Saturday and Sunday, January 13 and 14, 2015 by the Senior VP of Performance and Compliance. The policy was reviewed by the Senior VP of Clinical Services, the VP of Operations, and approved by the Chief Executive Officer on January 20, 2016.</p> <p>We will keep the problem from occurring going forward by continuing to monitor note timeliness and including it as a point of accountability for clinicians. In addition, we have made this a point of discussion in our metrics meeting with County Office Leadership.</p>		

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	notes by not submitting them within the 72 hours policy requires.				